New Jersey Department of Human Services
Division of Aging Services

PLAN OF CARE

1. **Participant Name** *(print)*	2. **Plan of Care Date** *(mm/dd/yyyy)*	3. **JACC No.**
4. **Case Manager Name** *(print)*	5. **Plan of Care Renewal Due** *(mm/yyyy)*	6. **Program:** ☐ JACC ☐ Other
7. **Residential Setting** ☐Private Residence ☐Class B Boarding Home	**Facility Name** ***(if applicable)***	

8	9	10	Services				Costs		Providers		Monitoring				Updates *	
			11	12	13	14	15	16	17	18	19	20	21	22	23	24
Date	**Problem Statement*: Identify Assessed Needs, Risk Factors and Personal Goals**	**Need Codes ***	**Service(s) Needed**	**Desired Outcome ***	**Units Per Visit**	**Frequency ***	**Unit Cost**	**Payment Source***	**Provider Type ***	**Provider**	**Monitoring Method ***	**Monitoring Frequency ***	**Back-up Plan* (If applicable)**	**Unmet Need Code * (if applicable)**	**Initials (CM, Clients)**	**Date**

PLAN OF CARE (Continued)

1. **Participant Name** *(print)*	2. **Plan of Care Date** *(mm/dd/yyyy)*	3. **JACC No.**

25. Special Instructions/Comments: [Include all of the following which apply – (1) Incorporate Client Preferences or Concerns; (2) Expound on Unmet Needs; and (3) Describe Back-up Plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns (including who is responsible with emergency contact information)] ☐ **N/A upon completion of initial POC**

Comment	Date	Comment	Date

Yes	No	
☐	☐	**I agree with this Plan of Care.**
☐	☐	**I had the freedom to choose the services in this Plan of Care.**
☐	☐	**I had the freedom to choose the providers of my services based on available providers.**
☐	☐	**I helped develop this Plan of Care.**
☐	☐	**I am aware of my rights and responsibilities as a participant of this program.**
☐	☐	**I am aware that the services outlined in this Plan of Care are not guaranteed.**
☐	☐	**I have been advised of the potential risk factors outlined in this Plan of Care.**
☐	☐	**I understand and accept these potential risk factors.**

Signature_____ ____/____/____

☐ Participant** / ☐ Representative** Date

Signatures:

Care Manager (CM): _____ Date: _____

CM Supervisor: _____ Date: _____

Facility: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

** Note: All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program.

* Code List

Problem Statement: (Column #10)
Briefly describe the client's individual circumstances which serve as the basis for each assessed need.

Need Codes: (Column #11)
Identify the Code by which each assessed need is best categorized.
Client Unable to:
1. Perform ADL (specify letter)
   a. Bathing
   b. Dressing
   c. Toilet Use
   d. Transferring
   e. Locomotion
   f. Bed Mobility
   g. Eating

Need Codes, Continued
2. Perform IADL (specify letter)
   a. Meal Preparation
   b. Housework
   c. Managing Finances
   d. Medication Management
   e. Phone Use
   f. Shopping
   g. Transportation
   h. Accessing Resources
   i. Laundry
   j. Personal Hygiene
3. Personal Goal
4. Communication Needs
5. Social Isolation
6. Caregiver Relief
7. Mental Health
8. Other (specify) _____

Need Codes, Continued
9. Risk Factors
   a. Personal Safety Risk
   b. Health Condition Risk
   c. Behavioral Risk
   d. Environmental Risk
   e. Medication Risk
   f. Other Risk (specify) _____

Desired Outcome Code: (Column # 13)
1. Maintenance
2. Independence
3. Rehabilitation
4. Prevention
5. Other (specify) _____

Frequency: (Column # 15)
D- Daily (specify # of days per week)
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
O- Other (specify) _____

Payment Source: (Column #17)
1. Medicaid
2. Medicare
3. Other Third Party Liability (TPL)
4. Local Community-Based Organization
5. County Funded Program
6. State Funded Program
7. Informal Support
8. Private Pay
9. Other _____

Provider Type: (Column #18)
T- Traditional (Medicaid Enrolled)
M- Medicare
N- Non-Traditional Provider
PEP- Participant-Employed Provider
P- Private Provider
F- Facility
I - Informal Support

Monitoring Method: (Column #20)
C- Participant Record/Chart
R- Receipts
S- On-Site Review
D- Documentation (specify) _____
P- Tele Contact with _____
O- Other (specify) _____

Monitoring Frequency: (Column #21)
D- Daily
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
R- Random
O- Other _____
U- Upon reported completion

Back-Up Plan: (Column # 22)
Y – Yes
If a Back-Up Plan is necessary for the delivery of a service that is critical to participant well being, indicate here and then explain Plan in Column #26.

Unmet Need Codes (Column # 23)
1. Not available
2. Not affordable
3. Waiting List
4. Frequency not adequate
5. Refused
6. Other (specify) - expound on reason if necessary in Column #26

Updates Columns # 24 and 25)
Completed only as necessary if changes are made throughout the duration of the Plan of Care.